intervals in a small percentage of cases. Since January 1, 1905, all "loop operations," with or without enteroanastomosis or closure of the pylorus, have been discarded, the gastric anastomosis being made as close to the origin of the jejunum as possible. Of fifty-six cases operated on in this way, two developed chronic biliary regurgitation of a serious character. Re-operation in both showed that the cause was an angulation of the jejunum at its gastric attachment, due to partial twisting as a result of suturing in the line of peristalsis. Since July 1, 1905, the reversing of the jejunum has been abandoned, and in a larger number of cases, sixty-five, not a single case gave trouble and no death has occurred. The jejunum is applied to the posterior wall of the stomach from right to left exactly as the intestine lies in the abdomen. The idea of reversing the peristalsis is not original with Mayo.

Traumatic Defects of the Skull; Their Relation to Epilepsy; A Clinical and Experimental Study of Their Repair.—ALLEN, SANFORD, and DOLLEY (*Boston Medical and Surgical Journal*, April 12, 1906) report seven cases in which traumatic defects in the skull were repaired by the implantation of grafts taken from another part of the skull, that consisted of an equal-sized area of pericranium and attached external layer of the skull. In the removal the bone necessarily was broken into small fragments. Any connective tissue covering the exposed portion of the brain is carefully removed. Since the scar tissue and dura are often inseparable the pia covering the brain may be thus exposed. The graft is carefully laid in position and covered with the scalp, a cigarette drain being employed for a few days. Healing by first intention occurred in every case, and the defect was repaired by what appeared to be bony structure. A macroscopic and microscopic study was made in a series of successful experimental grafts made on dogs.

Non-lithogenous Obstruction of the Biliary Ducts.—CORDIER (*Surgery, Gynecology, and Obstetrics*, April, 1906) reports one case in which the obstruction was due to an indurated mass just where the common duct passed behind the duodenum. This was the site where a large stone had ulcerated into the duodenum, and in healing had formed a complete stricture of the duct. The gall-bladder held four pints of bile and mucus, but no stone was found after a careful search of the ducts. An anastomosis was made between the gall-bladder and jejunum. The symptoms later disappeared entirely and three years after operation the patient was entirely well.

Strictures of the cystic duct are more likely to form than in the common duct. The surrounding structures are more dense and unyielding; there is no constant flow of bile to wash away infection from the intestine, or any sedimentary nucleus; and when once formed an obstruction tends to become complete. In such a case, cholecystostomy with drainage may be sufficient for treatment. With the subsidence of the acute symptoms, the canal becomes pervious, and bile begins to flow freely from the established fistula, when the end has been attained. It is better, however, when the gall-bladder is full of strictures to remove it, as in the case of the appendix. In the chronic cases, when the gall-bladder is a mass of scar tissue, a cholecystectomy should be done.

In a second case, a man, aged twenty-one years, had had attacks of "colic" since he was three years old. At operation, just where the common duct passed under the first part of the duodenum, the duct was as hard as a tendon, and appeared to be in very much the same pathological condition that is found in appendicitis obliterans (cholangitis obliterans). Cholecystojejunostomy was again performed with a Murphy button. Satisfactory cure resulted, which Cordier is afraid will not be permanent, owing to the change produced in the liver and spleen by the long-continued (eighteen years) obstruction. In a third case a similar condition resulted in the common duct, from the kick of a horse, and was cured by a similar operation. In a fourth case the cause was a chronic pancreatitis involving the ductal opening into the duodenum. One year after the performance of the operation the symptoms had not recurred. Cancerous invasion here is frequently due to the existence for a long time previously of some benign condition. Cancer of the bile passages occurs most frequently in the lower portion of the common duct, the location of most lithogenous obstructions.

Treatment of Varicose Veins.—Mayo (*Surgery, Gynecology, and Obstetrics*, April, 1906) thinks that the most common etiological condition is the existence of a congenital defect in the vein walls or valves, or in the innervation. There is a considerable question whether normal veins give way under the ordinary strain of life.

One hundred and eight-five operations have been done for varicose veins, many upon both limbs. The complete Schede operation has not been performed for several years; but a partial Schede, or oval or interrupted incision above or about a large ulcer, is frequently done, and combined with excision of the ulcer and skin grafting. The Trendelenburg operation is also done. Mayo has been partial to the excision of the long saphenous vein in the majority of cases. This is done by long incisions, leaving five or six inches of skin intact at the thigh, a pair of forceps being employed to enucleate and loosen the vein in the uncut area.

More recently he has employed a ring vein enucleator, which consists of a quarter-inch ring of steel with a long handle, the whole instrument being not unlike a blunt uterine curette bent to an angle near its tip. He has also had made for the same purpose a pair of long forceps, which form a ring at the end when closed. Beginning the operation above, the vein is exposed, ligated, and cut. The lower end of the vein is passed through the ring of the enucleator or the forceps. In this way by a gentle pushing force the vein is stripped from the surrounding tissues and the lateral branches torn off for six or eight inches, when a small incision is made in the skin and the isolated vein pushed through. The process is repeated downward in a similar manner.

Calculous deposits, sacculations, or extreme weakness of the vessel walls, render the case unsuited for this method, and this occurs in about 10 per cent. of the cases. Hemorrhage is prevented by elevation of the leg on an ordinary gynecological standard. This renders the limb partially bloodless and secures accessibility of the field of operation. More than ordinary hemorrhage from torn branches can be checked by pressure with a pad.